

# DREW DENTAL

783 Rio Del Mar Blvd. Aptos, CA 95003 831.688.6060 info@drewdental.com  
Family | Cosmetic | Invisalign | Implants

**PLEASE PRINT**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Sex: M F Birthdate \_\_\_\_\_

First MI Last

Single  Married  Partner  Widowed  Dependent Child Email \_\_\_\_\_

Address \_\_\_\_\_

City

State

Zip

Phone Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

(Friend or relative not living with you)

Referred by: \_\_\_\_\_

Physician or Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy (we can use to call in medication:) \_\_\_\_\_

Last Medical Exam \_\_\_\_\_ Premedication needed for appointments? \_\_\_\_\_

I give my consent to use local anesthetic, or relaxants for completing necessary dental treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

(parent if child is minor)

I, \_\_\_\_\_ I have received a copy of the DENTAL MATERIALS FACT SHEET.

(please print name)

Patient Signature (parent if minor) \_\_\_\_\_ Date: \_\_\_\_\_

**I understand I will also receive and acknowledge a copy of the Drew Dental privacy policy**

**Medical History**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Yes No

- Substance abuse
- Heart murmur/trouble
- Heart or chest pain
- Rheumatic fever
- Pacemaker
- Prosthetic valve
- Sinus problems
- High blood pressure
- Low Blood Pressure
- Recent cough or cold
- Facial radiation therapy

Yes No

- Lung disease
- Cancer
- Asthma
- Bronchitis
- Diabetes
- Kidney disease
- Liver disease
- Hepatitis
- Convulsions/epilepsy
- Nose obstruction
- Cortisone or ACTH

Yes No

- Thyroid condition
- Bleeding tendency
- Anemia
- Surgical implant
- Joint Replacement
- Venereal disease
- HIV positive
- Herpes
- Psychiatric treatment
- Headaches or ear pains
- High Cholesterol

**Allergy or unusual reaction to:**

Yes No

- Penicillin
- Clindamycin
- Sulfa
- Azithromycin
- Aspirin
- Milk
- Ibuprofen
- Valium/Halcion/Xanax
- Other Drugs \_\_\_\_\_

Yes No

- Latex
- Epinephrine
- Novocaine
- Norco/Vicodin
- Codeine
- Nitrous
- Acetaminophen

- Do you take anticoagulants / blood thinners? (incl. daily aspirin)  Yes  No explain \_\_\_\_\_
- Have you ever had excessive bleeding requiring special treatment?  Yes  No explain \_\_\_\_\_
- Have you ever taken bisphosphonates?  Yes  No such as zoledronate, pamidronate, fosamax, boniva, actonel
- Do you smoke?  Yes  No If yes how much? \_\_\_\_\_ pack(s) per day
- Do you get short of breath easily?  Yes  No explain \_\_\_\_\_
- Have you ever fainted?  Yes  No explain \_\_\_\_\_
- Have you ever had general anesthesia?  Yes  No explain \_\_\_\_\_
- Have you been hospitalized within the last 5 years?  Yes  No explain \_\_\_\_\_
- Are you under the care of a physician?  Yes  No explain \_\_\_\_\_
- Have you ever responded unfavorably to medical or dental care?  Yes  No explain \_\_\_\_\_
- Do you like to use Nitrous Oxide for dental visits?  Yes  No explain \_\_\_\_\_
- Do you like to use oral sedation for your dental treatment?  Yes  No Available options: Halcion, Valium, Xanax
- Must you sleep with your head on more than one pillow?  Yes  No explain \_\_\_\_\_
- Any medical condition or problems not listed above?  Yes  No explain \_\_\_\_\_
- Are you now taking any medications? Please list all medications**  Yes  No explain \_\_\_\_\_

**Women only:**

Pregnant?  Yes  No Breast feeding?  Yes  No Birth control pills?  Yes  No

Delivery date? \_\_\_\_\_ OB Dr. \_\_\_\_\_

**Dental Information**

- Are you in dental discomfort today?  Yes  No
- Do you clench or grind your teeth?  Yes  No
- Do you have frequent "tension" headaches?  Yes  No
- Are you missing any teeth?  Yes  No
- Have they been replaced?  Yes  No
- Do your gums bleed when you floss or brush?  Yes  No
- Have you been treated by a periodontist (gum specialist)?  Yes  No
- Have you ever had orthodontic treatment?  Yes  No
- Are any of your teeth sensitive to:  Hot?  Cold?  Sweets?  Pressure?
- Previous dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_
- How long has it been since your last dental treatment? \_\_\_\_\_ How do you feel about the appearance of your teeth? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Provider Signature \_\_\_\_\_

**Updates**

Changes: Yes/No? Signature \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

Changes: Yes/No? Signature \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

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